CALIFORNIA STATE DEPARTMENT OF PUBLIC HEALTH
WALTER M. DICKIE, M.D., Director

Weekly Bulletin

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*Administration of the Venereal Disease Program in a Rural Territory**

By R. C. MAIN, M.D., County Health Officer, Santa Barbara

In certain respects our efforts to reduce the incidence and the ravages of the venereal diseases are necessarily the same, whether we are working in rural areas or in metropolitan districts. Since intimate contact is the common, almost exclusive, means of spread, their epidemiology is not so closely correlated with density of population as in the case with respiratory diseases. Neither is the sanitation of the environment so important as with intestinal infections.

But there are certain other important characteristics which distinguish the public health aspect of venereal diseases in the country and small towns from that with which the city health officer must deal. Some of these factors are helpful and others increase and complicate the difficulties. We know, of course, that commercial prostitution does not thrive in the small community. It is too quickly spotted and much more vulnerable. Moreover, as a means of spread of disease, the rural prostitute is easily identified by the victim, whereas in large brothels, with frequent change in personnel, the exact source of infection is often unknown. Besides fewer foci of infection, there may also be more continence, whether imposed by circumstances or resulting from a stricter moral code among rural dwellers. In any case, we have conclusive evidence from many careful surveys that the incidence of fresh venereal infections is very much lower in the country than in the city—possibly not more than one-fourth as common.

It might seem, therefore, that the control of venereal diseases in the rural districts would be comparatively easy; but that is not so, for there are other circumstances which tend to make the problem more difficult in the country.

Our rural dwellers are rugged individualists to a far greater degree than the modern city dweller. If there is any group in which the pioneer spirit of self-reliance has been preserved, it is the farmer and small villager. They are not familiar with clinics or other group activities. It is a fact of some significance, also, that the everyday movements of a rural dweller are known to his neighbors. He can not back out the car and start to town without the neighborhood knowing it, whereas in a city apartment house one may not know or even recognize the occupants across the hall or have any interest in their going and coming. There is no isolation so complete as isolation in a crowd. The same caution which protects him from infection and the difficulties of secrecy which he encounters inhibits the rural dweller's efforts to institute and pursue proper treatment. And here

* Read before the Department of Health Officers at the convention of the League of California Municipalities held in Santa Barbara September 7, 1938.

we touch the very core of control measures, for it is *treatment* upon which we chiefly rely in venereal disease control as in no other disease. And we in this country know only too well that it is the taboo of the subject that constitutes our greatest obstacle to a sane, effective program. Again, it requires much more effort on the part of the patient to follow a prolonged course of treatment when the clinic is some distance from his home. Hours of employment are longer than in industry, making even night appointments difficult to keep. The purchases of gasoline and tires enhances the cost appreciably and makes even free clinic treatment still an expensive procedure.

Now, what have we done in the country to overcome our peculiar difficulties? To aid the patient in maintaining secrecy, we find it better not to have separate establishments for the treatment of venereal diseases nor definite hours for such patients. A general clinic is more acceptable and involves little risk or inconvenience. We find it an advantage to offer treatment through the general practice of private physicians and we are convinced that the private practitioner, if properly trained and thoroughly experienced, is in the best position to render the needed service in a rural program.

Our next consideration is to bring the service as close as possible to the patient, as a matter of economy to him, so that he will be less likely to lapse or become discouraged. That means the part-time employment of a private physician in each hamlet or community to represent the health department in giving treatment and procuring epidemiological information from patients. To be sure, there are serious drawbacks to such an arrangement. Good syphilologists are not common in rural districts. Nor is the average practitioner much interested in the epidemiological information from patients.

But, on the other hand, as clinician he does have an intimate relation to the patient which enables him to procure information not readily forthcoming to a nurse or to a clerk or a history taker in the large clinic. It is our experience, also, that participation of the general practitioner in such a program rapidly enhances his interest and increases his skill in the handling of these patients, in planning courses of treatment, and in procuring essential information as to sources of infection. We hope and expect that the quality of service will improve, with the help and supervision of our California Bureau of Venereal Diseases.

The problem of venereal disease control in a rural community is therefore easily visualized. As I see it, it is more difficult than the problems in the city in three respects and easier in one. The difficulties are to bring the treatment facilities within reach of the patient geographically, to guard against disclosure of the patient's condition, and to improve the quality of the medical service.

THE ADMINISTRATION OF A VENEREAL DISEASE CONTROL PROGRAM IN A LARGE COUNTY*

By P. Richard Auriemma, M.D., Chief, Division of Social Hygiene, Los Angeles County Health Department

By reason of the extensive geographical area under the jurisdiction of a county, the administrative facilities of a venereal disease control program confronts the problems inherent to combined state, city, and rural jurisdictions. Facilities must be set up in cities, towns, villages and unincorporated areas, the structure of which must be such that efficient service may be readily available and capable of being rendered to every individual.

As a unique example of a very satisfactory arrangement, the health center plans in use in Los Angeles County may be cited. Here local health units are established at strategic points throughout the county, with branch centers attached where needed and the whole controlled by centralized authority. Each health center unit and its branches is in fact a small health department by itself; it is under the administrative control of a district health officer, who has a complete staff, such as medical social worker, supervising nurse, clinic and field nurses, bacteriologist, sanitarian, etc.

The county health officer, located in central office in Los Angeles, is the director. Here also are the officers of bureau and division heads.

Formerly, venereal disease clinics were manned by local private physicians. The arrangement was not satisfactory as there were twelve to fifteen physicians treating patients according to standards they had acquired in their separate medical schools, some of the standards being very old. Private work sometimes interfered with clinic work and the personnel administration problem was difficult. Accordingly a rearrangement was made, gradually leading to the present set-up. This consists of a chief venereal control officer located in the central office, a corps of full-time, trained clinicians, and some other specialized personnel.

The chief outlines policies; sets standards; advises the county health officer; builds up and maintains

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satisfactory relationships with private physicians; controls the educational program and gives lectures and talks; directs the work of the clinicians; assists and acts as consultant when necessary; and cooperates with central and local personnel in order to round out and keep in smooth working condition an effective program.

The venereal disease clinician is in charge of the actual handling of the patient from the taking of the history and making the diagnosis through to treatment and cure. He maintains a regular clinic schedule, travels from health center to health center, and is assisted in the execution of his work by local personnel. When patients appear between clinic schedules they are given emergency care by the health officer, then routed to the next clinic. Special problems, new medical procedures, study of cases, etc., are taken up at twice-monthly staff meetings.

Such a decentralized plan as outlined would appear to result in duplication of effort and overlapping, but actually this is prevented by centralized control, and the fact is, all personnel function to the limit of their capacities. Medical and social service are brought to the front door of the patient; ambulatory patients, many of whom might find their way into and clutter up beds in the county hospital, are retained and controlled locally, thus saving money to the taxpayer. Local private physicians are relieved of the burden of taking care of many indigent and socially underprivileged persons. Local political control of health department activities is eliminated or minimized, and above all coordinated and complete epidemiological, laboratory, medical social service, other technical accessory services, and the skilled medical services of physicians spending all their time in venereal disease control work and using the most modern and best recommended standards, all are available to the individual in city, town, or county. On the whole, the consistent service thus offered is much better than can be obtained locally in most instances and at a cost much lower than if each community had its own individual organization, giving the same grade of care.

It is the opinion of those who best understand the physical system, that if the physical laws were strictly observed from generation to generation, there would be an end to the frightful diseases that cut life short, and of the long list of maladies that make life a torment or a trial, and that this wonderful machine, the body—this "goodly temple"—would gradually decay, and men would at last die as if gently falling asleep.—Mrs. Sedgwick.

DISEASES REPORTABLE IN CALIFORNIA

REPORTABLE ONLY

Anthrax
Beriberi
Botulism
Chancroid
Coccidioidal Granuloma
Dengue*
Fluke Infection
Food Poisoning
Glanders†
Hookworm
Jaundice (Infectious)
Lymphogranuloma Inguinale
Malaria*
Pellagra
Pneumonia (Lobar)
Relapsing Fever
Rocky Mountain Spotted Fever
Septic Sore Throat
Tetanus
Trichinosis
Tularemia
Undulant Fever

ISOLATION OF PATIENT

Chickenpox
Dysentery (Amoebic)
Dysentery (Bacillary)
Erysipelas
German Measles
Gonococcus Infection
Influenza
Measles
Mumps
Ophthalmia Neonatorum
Psittacosis
Rabies (Animal)
Rabies (Human)
Syphilis
Trachoma
Tuberculosis
Whooping Cough

QUARANTINABLE

Cholera†
Diphtheria
Encephalitis (Epidemic)
Leprosy
Meningitis (Epidemic)
Plague†
Acute Anterior Poliomyelitis
Scarlet Fever
Smallpox
Typhoid and Paratyphoid Fever
Typhus Fever
Yellow Fever†

* Patients should be kept in mosquito-free room.
† Cases to be reported to State Department of Public Health by telephone or telegraph and special instructions will be issued.

In 1937, 64,397 marriages were registered in California, as compared with 60,197 marriages in 1936. This is an increase of 4200. The state marriage rate for 1937 was 9.8 per thousand population. The rate for Orange County that year was 32.8—more than three times the state rate. There were 4603 marriages performed in Orange County last year, as compared with 4454 in Alameda County with its much greater population. It would appear that Orange County is now the Gretna Green of California. Sierra County had the lowest marriage rate of any county in the state last year. There were three marriages registered there, giving a rate of 1.1. In Alpine County, two marriages were recorded, giving a rate of 8.3.

The building of a perfect body crowned by a perfect brain, is at once the greatest earthly problem and grandest hope of the race.—Dio Lewis.

MORBIDITY

Complete Report for Following Diseases for Week Ending October 15, 1938

Chickenpox

181 cases: Alameda County 7, Berkeley 3, Hayward 17, Oakland 22, Pleasanton 2, Fresno County 6, Fresno 3, Reedley 3, Kern County 2, Lassen County 4, Los Angeles County 1, Alhambra 1, Arcadia 1, Long Beach 1, Los Angeles 8, Marin County 2, Mendocino County 2, Monterey County 1, Orange County 1, Fullerton 1, Newport Beach 1, Santa Ana 2, Sacramento 1, Ontario 1, San Diego 4, San Francisco 51, San Joaquin County 1, Stockton 6, San Mateo County 1, San Bruno 2, Santa Barbara County 7, Santa Barbara 3, Santa Clara County 1, San Jose 3, Sunnyvale 5, Solano County 2, Tulare County 1, Ventura County 1.

Diphtheria

26 cases: Berkeley 2, Firebaugh 1, Brawley 1, Los Angeles County 4, Azusa 1, Glendale 1, Los Angeles 5, Gardena 1, Orange County 4, San Francisco 1, Lodi 1, Sonoma County 1, Santa Paula 1, Yolo County 1, Yuba County 1.

German Measles

24 cases: Alameda County 3, Alameda 1, Berkeley 2, Oakland 3, Kern County 1, Long Beach 1, Los Angeles 3, Santa Ana 2, San Francisco 2, Daly City 1, Santa Clara County 1, Los Gatos 1, Sonoma County 2, Tehama County 1.

Influenza

13 cases: Lassen County 1, Los Angeles County 1, Los Angeles 5, Brea 1, Roseville 1, Riverside 1, San Joaquin County 1, Sonoma County 1, Oxnard 1.

Malaria

34 cases: Fresno County 8, Placer County 1, Yuba City 1, Tulare County 23, California 1.*

Measles

200 cases: Albany 1, Oakland 9, Butte County 1, Contra Costa County 3, Antioch 1, Concord 1, Placerville 1, Kern County 2, Bakersfield 8, Lassen County 1, Los Angeles County 4, Long Beach 6, Los Angeles 4, Maywood 1, Grass Valley 1, Orange County 6, Santa Ana 2, Elsinore 1, Riverside 1, Sacramento County 1, San Diego 1, San Francisco 100, San Joaquin County 1, Stockton 12, Tracy 1, Santa Clara County 17, San Jose 9, Santa Clara 1, Sonoma County 1, Tehama County 1, Tulare County 1.

Mumps

302 cases: Alameda County 5, Albany 8, Berkeley 34, Emeryville 11, Oakland 81, Pleasanton 3, Contra Costa County 6, Antioch 1, Concord 2, Walnut Creek 2, Fresno County 4, Fresno 2, Kern County 4, Bakersfield 2, Los Angeles County 6, Glendale 1, Huntington Park 2, Long Beach 1, Los Angeles 5, Pasadena 1, San Fernando 1, Sierra Madre 1, Hawthorne 1, San Anselmo 1, Mendocino County 12, Merced County 1, Monterey County 2, Napa 1, Orange County 3, Anaheim 1, Fullerton 1, Orange 3, Santa Ana 4, Roseville 4, Riverside 1, Sacramento 4, San Bernardino County 1, San Diego County 2, Coronado 1, San Diego 7, San Francisco 17, San Joaquin County 9, Stockton 12, San Luis Obispo 2, Santa Barbara 3, Los Gatos 2, San Jose 3, Santa Cruz County 1, Sierra County 12, Newman 1, Oakdale 2, Exeter 3, Winters 1, Yuba County 1.

Pneumonia (Lobar)

10 cases: Oakland 1, Fresno County 1, Los Angeles 4, Napa County 1, San Francisco 2, Santa Cruz County 1.

Scarlet Fever

106 cases: Butte County 1, Fresno County 5, Reedley 1, Kern County 4, Los Angeles County 9, Inglewood 1, Compton 1, Long Beach 4, Los Angeles 25, Montebello 1, Monterey Park 1, Bell 2, Madera County 1, Merced County 1, Roseville 1, Indio 2, Sacramento 4, San Bernardino 2, San Diego County 1, San Francisco 4, San Joaquin County 5, Stockton 4, Santa Barbara County 7, Santa Barbara 5, Santa Clara County 2, Santa Clara 1, Vallejo 1, Modesto 4, Tulare County 2, Lindsay 1, Ventura County 1, Ventura 1, Yolo County 1.

Smallpox

One case: Santa Clara County.

Typhoid Fever

13 cases: Long Beach 1, Torrance 1, Merced County 2, Lincoln 1, Sacramento 1, San Francisco 1, Santa Clara County 3, Santa Clara 1, Santa Cruz County 1, Yolo County 1.

Whooping Cough

130 cases: Alameda County 2, Berkeley 11, Oakland 5, Contra Costa County 3, Fresno County 5, Fresno 1, Kern County 4, Los Angeles County 4, Inglewood 1, Long Beach 1, Los Angeles 13, Montebello 1, Pasadena 3, San Fernando 3, Sierra Madre 1, Whittier 1, South Gate 1, Madera County 5, Madera 1, Marin County 2, Grass Valley 1, Riverside 1, San Diego 6, San Francisco 33, San Joaquin County 1, Daly City 1, Santa Barbara County 1, Lompoc 1, San Jose 2, Santa Cruz 2, Sonoma County 1, Dinuba 2, Ventura County 4, Oxnard 3, Santa Paula 3.

Dysentery (Amoebic)

9 cases: Los Angeles 1, San Bernardino County 1, Ontario 5, San Francisco 1, Santa Barbara 1.

Dysentery (Bacillary)

19 cases: Contra Costa County 1, Fresno County 1, Los Angeles County 2, Compton 1, Los Angeles 2, Hawthorne 1, Madera 1, Sacramento County 1, San Benito County 1, Sonoma County 8.

Leprosy

One case: San Francisco.

Ophthalmia Neonatorum

Two cases: Los Angeles.

Poliomyelitis

3 cases: San Diego 1, San Luis Obispo 1, Santa Cruz County 1.

Tetanus

2 cases: Los Angeles.

Trachoma

2 cases: San Francisco 1, Santa Clara County 1.

Encephalitis (Epidemic)

4 cases: Fresno County.

Paratyphoid Fever

2 cases: Marin County 1, Tuolumne County 1.

Trichinosis

2 cases: Antioch 1, San Diego 1.

Typhus Fever

One case: San Diego.

Undulant Fever

4 cases: Los Angeles County 1, Placer County 1, San Bernardino County 1, Vallejo 1.

Coccidioidal Granuloma

2 cases: Glendale 1, San Mateo County 1.

Septic Sore Throat

One case: San Francisco.

Relapsing Fever

One case: California.*

Rabies (Animal)

20 cases: Kern County 2, Los Angeles County 2, Los Angeles 2, Monterey County 1, Hollister 2, Menlo Park 1, Santa Clara County 5, Mountain View 1, Santa Clara 1, Tulare County 1, Porterville 1, Tulare 1.

Regimen is better than physic. Every one should be his own physician. We ought to assist and not to force nature. Eat with moderation what agrees with your constitution. Nothing is good for the body but what we can digest. What medicine can procure digestion? Exercise. What will recruit strength? Sleep. What will alleviate incurable evils? Patience. —Voltaire.

* Cases charged to "California" represent patients ill before entering the state or those who contracted their illness traveling about the state throughout the incubation period of the disease. These cases are not chargeable to any one locality.

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